

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008726	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/02/2016
NAME OF PROVIDER OR SUPPLIER SOUTH LAWN SHELTERED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 512 SOUTH FRANKLIN BUNKER HILL, IL 62014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation #1640498/IL83018	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 330.710a) 330.710b) 330.710c)1)2)3)A)B)C)D)E)F)G) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public. c) The written policies shall include, but are not limited to, the following provisions: 1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers. 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services. 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

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S9999	Continued From page 1 with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances. E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury. F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. G) Consideration of the feasibility of incorporating resident handling equipment or the physical space and construction design needed to incorporate that equipment when developing architectural plans for construction or remodeling of a facility or unit of a facility in which resident handling and movement occurs. (Section 3-206.05 of the Act)	S9999		

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S9999	Continued From page 2 Based on interview and record review, the Facility fails to develop and follow written policies. This has the potential to affect all 38 residents living in the Facility. Findings include: On 1/28/16, at 10:55 AM, E1, Administrator, was asked if the Facility has a policy regarding Abuse. E1 said that he was unable to locate any policies and procedures. E1 said that if the Facility has policies and procedures, he doesn't know where they are located. The Facility Data Sheet, dated 1/28/16, documents that there are 38 residents currently living in the Facility. (AW) 330.720e)1)2)3)4) 330.1710f)1)2) 330.4240f) Section 330.720 Admission and Discharge Policies e) No person shall be admitted to or kept in the facility: 1) Who is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation; 2) Who is destructive of property and that	S9999		

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S9999	Continued From page 3 destruction jeopardizes the safety of her/himself or others; 3) Who has serious mental or emotional problems based on medical diagnosis; or 4) Who is an identified offender, unless the assessment requirements of Section 330.715 for new admissions and the requirements of Section 330.725 are met. Section 330.1710 Resident Record Requirements f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. 2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or rehabilitation services, shall be included in the resident's progress record when the recommendations pertain to an individual resident. Section 330.4240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) (Source: Amended at 15 Ill. Reg. 516, effective January 1, 1991)	S9999			

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S9999	Continued From page 4 Based on record review and interview, the Facility admits and keeps residents with medical diagnoses of serious mental and/or emotional problems, for 1 or 1 residents (R3) in the sample of 12 who has aggressive behaviors. The Facility failed to assess for and establish behavioral goals, in order to determine progression and regression of inappropriate behaviors, for 1 of 1 residents (R3) in the sample of 12. The Facility failed to immediately evaluate an aggressive resident to determine the most suitable therapy and placement, while considering the safety of other residents, for 11 of 12 residents (R1, R3, R4, R5, R6, R7, R8, R8, R10 R11 and R12) involved in resident-to-resident altercations, in the sample of 12 Findings include: Facility admission sheet documents that R3 was originally admitted to the Facility on 10/26/15 with a diagnosis of Schizophrenia, BiPolar Type. There is no plan of care or behavior tracking documented in R3's clinical record. R3's Progress Note, from the hospital, dated 1/4/16, documents "Followed for Schizoaffective Disorder, BiPolar Type. Came with owner of the Home. Report from nursing staff that patient has been loud, screaming and pointing fingers at staff and other residents, has been disruptive, and had hit other residents, calling police and stating that other residents hit him. He has been cursing at staff on a daily basis. Patient has a history of verbal and physical aggression and poor compliance with his medicine/treatment." Facility "Incident/Accident" Reports, dated 1/1/16 and 1/11/16, document verbal and physically	S9999		

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S9999	<p>Continued From page 5</p> <p>aggressive behaviors towards staff and other residents. The 1/11/16 Report documents that R3 was taken to the hospital and admitted to the Psychiatric Unit.</p> <p>On 1/28/16, at 9:19 AM, E1, Administrator, said that R3 has had behavior problems directed towards staff and other residents since his admission to the Facility. E1 said that he took R3 to the hospital about 10 days ago to adjust his medication "but, he's worse than ever. He's verbally abusive, uses name-calling and calls everyone a liar. I took him back conditionally." E1 said that the Facility never assessed R3 for behaviors, nor did they develop a plan of care to mitigate R3's behaviors. E1 said that "it was just verbal." E1 said that he would try talking to R3 but, said it did not good to try talking to R3. E1 said that he would tell R3 to go to his room or smoke outside the side door instead of on the porch with the other residents.</p> <p>R3's nurse's notes document "1/7/16, 1:00 PM, Resident aggressive toward other residents - cussing people out, name calling, getting up in other resident's faces and threatening them with physical violence. Saw psychiatrist on 1/4/16 related to the increase in behaviors and new orders received that day. All aggression/anger/threats unwarranted and unprovoked by other residents. Resident was talked to about behaviors and agreed to use other outlets of expression, like talking to staff and journaling, to no avail. 1/11/16, 7:40 AM, Writer arrived at 6:00 AM this morning and resident on the ground in the dining room in a physical altercation with another resident. Both residents separated and writer noted laceration under (R3's) left eye with abrasion above left eyebrow. Direct pressure applied and resident sitting in</p>	S9999			

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S9999	<p>Continued From page 6</p> <p>chair at the table. Writer educated resident on rules of no fighting and being verbally abusive to others. (E1), Administrator, notified - came to Facility and took resident to the hospital emergency room for evaluation, with direct pressure on the left eye laceration."</p> <p>On 1/28/16 at 9:15 AM, E2, Licensed Practical Nurse (LPN), said that early evening on 1/25/15, R3 picked up a chair and threatened to throw it at E4, but he missed. E2 said "(R3) is a typical Schizophrenic - he gets in people's faces, threatens others with physical violence, verbal threats, curses them out, tells them they're crazy. He's a pathological liar. He's verbally aggressive when he doesn't get his way. He's a very paranoid Schizophrenic. Very belligerent." E2 confirmed that the Facility does not have any type of assessed behavior tracking with interventions for R3. E2 said that she was not working when the chair-throwing incident occurred so, an incident investigation was not done. E2 said that most of R3's behaviors have not been documented. E2 said that none of the employees have ever received any training on how to deal with resident behaviors. E2 said that R3 curses at staff and residents, and many of them are afraid of him.</p> <p>1. Facility "Incident/Accident" Report, dated 1/1/16 documents "(R3) approached (R11) on the front porch and called (R11) names and grabbed (R11's) walker. (R11) jerked his walker back then, they yelled names at each other for a few minutes. (R3) called the police and reported that (R11) hit him several times with his walker. The officer talked to witness (R12) and she confirmed that (R3) was lying. (R12) said (R3) started it by name-calling and grabbing (R11's) walker. The only thing that (R11) did was just jerk his walker</p>	S9999		

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S9999	Continued From page 7 away from (R3)." Facility "Incident/Accident Report", dated 1/11/16, documents that "(R3) has been non-stop since 11:50 AM. He cussed me out because he said that I called him a F--king liar. Then he called the drug delivery man a B-tch for no reason at all. He was calling everyone b-tches or fag-t, F this and F that, c-nt, mother f-cker. He talked about blowing the place up with an assault rifle. He told me that I'm fat and can't walk. We need curfew in the dining room. At 3:45 PM, (R3) was crying, talking about killing and death. At 5:20 PM, (R3) was getting loud again. He called (R10) a b-tch. At 5:55 PM, (R3) was outside cussing at (R1), call him a b-tch and trying to get money from (R1). (R3) walked back in the door, (R1) told (R3) to stop cussing at him, threatening him and trying to get money from him. (R1) then doubled up his fist and swung at (R3), and missed. Then (R3) pushed (R1), doubled up his fist and started after (R1). (R3) fell and (R1) fell too. (R3) was beating (R1) on his upper back. (R1) got (R3) in a headlock. I tried to break them up but couldn't." The Report documents that R3 was taken to the hospital and admitted to the Psychiatric Unit. There is no documentation that the police were notified. R3's nurse's notes document "1/7/16, 1:00 PM, Resident aggressive toward other residents - cussing people out, name calling, getting up in other residents faces and threatening them with physical violence. Saw psychiatrist on 1/4/16 related to the increase in behaviors and new orders received that day. All aggression/anger/threats unwarranted and unprovoked by other residents. Resident was talked to about behaviors and agreed to use other outlets of expression, like talking to staff and	S9999		

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S9999	Continued From page 8 journaling, to no avail. 1/11/16, 7:40 AM, Writer arrived at 6:00 AM this morning and resident on the ground in the dining room in a physical altercation with another resident. Both residents separated and writer noted laceration under (R3's) left eye with abrasion above left eyebrow. Direct pressure applied and resident sitting in chair at the table. Writer educated resident on rules of no fighting and being verbally abusive to others. E1, Administrator, notified - came to Facility and took resident to the hospital emergency room for evaluation, with direct pressure on the left eye laceration." E1, Administrator, stated on 1/28/16 at 10:55 AM, "I wasn't here when (R3) threw the chair at (R4). He didn't hit him. I talked to (R3). He always says it's the other guys fault. He says that everyone is lying. (R3) got into it with (R1) too so I took him to the hospital to get his medication adjusted. (R4) wanted to call the police but, since he didn't get hit I told him not to." E1 confirmed that the Facility has not assessed R3 for behaviors nor have they instituted any type of behavior interventions. On 1/28/16 at 10:36 AM, R4 said that on Monday he and a friend were sitting on the front porch talking. R3 kept butting into the conversation. R4 said that he asked R3 to mind his own business but R3 kept interrupting. R4 said "by the fourth time, I told (R3) to shut the F-ck up!" R3 went inside the Facility. "A little while later, I went inside to the bathroom. I came back through the dining room. I started to go outside the front door and (R3) picked up a chair over his head and threw it at me. I seen it coming and stepped out of the door. I told (E1) about it when he showed up an hour later and he didn't do anything. I wanted to call the police and he begged me not	S9999			

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S9999	Continued From page 9 to. We're all scared that (R3's) gonna hurt someone. (E1) won't do anything about it." On 1/28/16, at 10:28 AM, R8 said "(R3) is a terror to the whole place. He constantly tears you down. He threatens to kill us all. He said that he has a Colt 45. He calls us witches, b-tches, and other names. I can't take it anymore - my stomach is in knots! I makes me cry, and I'm scared. He says that we are all devils and he tries to make us give him money." On 1/28/16 at 10:10 AM, R5 said that R3 is always cursing at the other residents. R5 said "the other day he picked up a chair and almost hit the heads of 2 or 3 residents. It scared me. He's dangerous and he scares me. I told (E1) and (E1) told (R3) to go to his room. He is worse now more than ever. Some (residents) started crying." On 1/28/16 at 10:15 AM, R6 said that "(R3) called me a G-d da-n b-tch just this morning. (R3) threw a chair at (R4) the other day. (R4) wanted to call the police and (E1) wouldn't let him. I heard him tell (R3) not to call the police. (E1) sent (R3) to his room. He verbally abuses everyone. It's awful! (E1) tries to appease him by buying him sodas and stuff. I'm scared of (R3). I don't know what he's gonna do." R6 was crying throughout the interview. On 1/28/16 at 10:00 AM, R7 said "my nerves are shot. (R3) causes a lot of problems. He harasses us all. He pushes and shoves at me. He's overbearing, ornery and causes fights. He's making me very stressed and anxious. He's affecting my health. My ulcers are worse. My friend shakes whenever (R3) is around and is having trouble eating. You never know what he'll	S9999		

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S9999	<p>Continued From page 10</p> <p>do - it's terrible."</p> <p>On 1/28/16 at 11:05 AM, R9 said "This guy, (R3) is causing trouble for all of us. He's threatened me. He threw a chair at (R4). He tried to beat up (R1). I'm trying to stay away from him but it's difficult. I'm tired of it."</p> <p>R3's Progress Note, from the hospital, dated 1/4/16, documents "Followed for Schizoaffective Disorder, BiPolar Type. Came with owner of the Home. Report from nursing staff that patient has been loud, screaming and pointing fingers at staff and other residents, has been disruptive, and had hit other residents, calling police and stating that other residence hit him. He has been cursing at staff on a daily basis. Patient has a history of verbal and physical aggression and poor compliance with his medicine/treatment."</p> <p>Facility admission sheet documents that R3 was originally admitted to the Facility on 10/26/15 with a diagnosis of Schizophrenia, BiPolar Type. (A)</p>	S9999			

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: South Lawn

DATE AND TYPE OF SURVEY: February 2, 2016

COMPLAINT INVESTIGATION 1640498/IL83018

Attachment B Imposed Plan of Correction

Section 330.710 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public.

c) The written policies shall include, but are not limited to, the following provisions:

1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers.

2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services.

3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following:

A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs.

B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling.

C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment.

D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances.

E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury.

F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.

G) Consideration of the feasibility of incorporating resident handling equipment or the physical space and construction design needed to incorporate that equipment when developing

architectural plans for construction or remodeling of a facility or unit of a facility in which resident handling and movement occurs. (Section 3-206.05 of the Act)

Section 330.720 Admission and Discharge Policies

- e) No person shall be admitted to or kept in the facility:
 - 1) Who is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation;
 - 2) Who is destructive of property and that destruction jeopardizes the safety of her/himself or others;
 - 3) Who has serious mental or emotional problems based on medical diagnosis; or
 - 4) Who is an identified offender, unless the assessment requirements of Section 330.715 for new admissions and the requirements of Section 330.725 are met.

Section 330.1710 Resident Record Requirements

- f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.
 - 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.
 - 2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or rehabilitation services, shall be included in the resident's progress record when the recommendations pertain to an individual resident.

Section 330.4240 Abuse and Neglect

- f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

(Source: Amended at 15 Ill. Reg. 516, effective January 1, 1991)

THIS WILL BE ACCOMPLISHED BY:

- I. A committee consisting of, at a minimum, the Medical Director, Administrator and Director of Nursing (DON) will review and revise the policies and

Attachment B
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procedures regarding abuse and neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

- A. Recognition of situations that could be interpreted as abusive or neglectful.
- B. Appropriate reporting procedures for staff.
- C. Appropriate and thorough investigations of alleged abuse or neglect.
- D. The facility's responsibilities to prevent further potential abuse while investigation is in progress.
- E. The facility taking appropriate corrective action when an alleged violation is verified.
- F. Policies will be made available for all staff and State Survey agency to review.
- G. The resident's record will reflect changes in behavior, or in new admits will institute behavior tracking.
- H. Facility will follow the regulation and not admit serious mentally ill.

II. The facility will conduct mandatory in-services for all staff within 30 days that addresses, at a minimum, the following:

- A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this plan of correction.
- B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
- C. Documentation of these in-services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the administrator's office.

III. The following action will be taken to prevent re-occurrence:

- A. The above in-service education will be reviewed with all staff on a regular basis.
- B. Supervisory staff will ensure that the State Regulations regarding abuse/neglect allegations (reporting and follow-up) are followed.

IV. The Administrator and Director of Nursing will monitor items I through III to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten days from receipt of the Imposed Plan of Correction. /sf

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